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Dissociative identity disorder: Understanding its roots in childhood experiences.

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ABSTRACT

This paper examines Dissociative Identity Disorder (DID) and how it is potentially rooted in childhood experience. The paper provides an analysis of the characteristics of DID and the history of the diagnosis as well as current conceptualizations of the disorder. The paper explores current understandings of the causes of the disorder and highlights various findings that indicate the potential role of childhood experiences and trauma in DID. Reasons for linking DID with childhood experiences are discussed; these include the long-lasting effects of trauma that occurs during the developmental stage of childhood. The paper also analyzes the comorbidity of Dissociative Disorders with other psychological and/or health conditions. Integrative treatment that addresses the complexity and the rarity of the DID is also reviewed. The paper concludes with an understanding of DID as being significantly connected to early traumatic experiences that may interact with potential biological vulnerability and/or the individual's social environment. The analysis calls for further research into DID.

The process of dissociation when referred to as part of psychological disorders can be differentiated from the dissociative phenomena that most individuals experience periodically. As the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* explains, individuals suffering from dissociative disorders show disintegration between the cognitive, social, physical and behavioral aspects of the individual. This disintegration or disruption differentiates dissociative disorders from the normal and benign dissociation individuals sometimes face in their day to day life.

As Kennedy et al. (2013) mention, recent studies conducted on dissociative disorders tend to indicate a high rate of comorbidity with various other disorders and dissociative disorders may have roots in childhood experiences. This paper aims to explore the relationship between *Dissociative Identity Disorder (DID)* and childhood experiences and take a closer look at the characteristics of the rare condition. The paper also tries to understand the causes of DID and its co-occurrence with other disorders and mental conditions. It is followed by a look into the current conceptualizations and integrative treatment options for the disorder.

The history of interest in dissociation can be traced back to the sixteenth century. Discussions by Kennedy et al. (2013) identify that the instances of possession and witchcraft were sometimes viewed as instances of dissociation. The understanding of the phenomena in the 16th century

provided a point of reference from which our contemporary understanding of dissociation emerged.

By the late nineteenth century, ideas about dissociation were connected to concepts like hypnosis and hysteria. These new ways of looking at dissociation evolved into a many different models for explaining dissociation. One of these models *dichotomy model of dissociation*.

The *dichotomy model of dissociation* was developed in the 21st century. This model binds two qualitatively different phenomena – 'detachment' and 'compartmentalization'. As Kennedy et al. (2013) elucidates, " 'Detachment' incorporates depersonalization and derealization, 'spacing-out', feelings of unreality that occur with little disturbance to sense of identity. It has been observed to co-occur with trauma" (p. 12). Meanwhile, " 'Compartmentalization' has been observed to be the inability to bring normal accessible information to conscious awareness. It can influence emotion, cognition and action and the two distinct categories may occur concurrently during certain conditions such as PTSD " (p. 12-13). *Figure 1* illustrates this dichotomy.

The *dichotomy* model is useful in a systematic approach to the treatment of dissociation. Treatment can be focused on the cues of detachment if the diagnosis involves difficulties with the detachment whereas, treatment addressing compartmentalization elements of dissociation can work toward a reintegration of information in order to bring it into conscious awareness. The model may also serve to break down the presenting problem of the client, and can be instrumental in studying comorbidity of dissociation with other psychological disorders. Another consideration is the process of dissociation and it's relationship to neural connections – "dissociative processes may be understood in the connection of possible reversible blocking of the transmission from one hemisphere to the other across the corpus callosum and other commissural fibers. It may lead to the competition and chaotic states" (Bob, 2003, p. 911). In neurophysiological contexts, dissociation may be understood as the blocking of

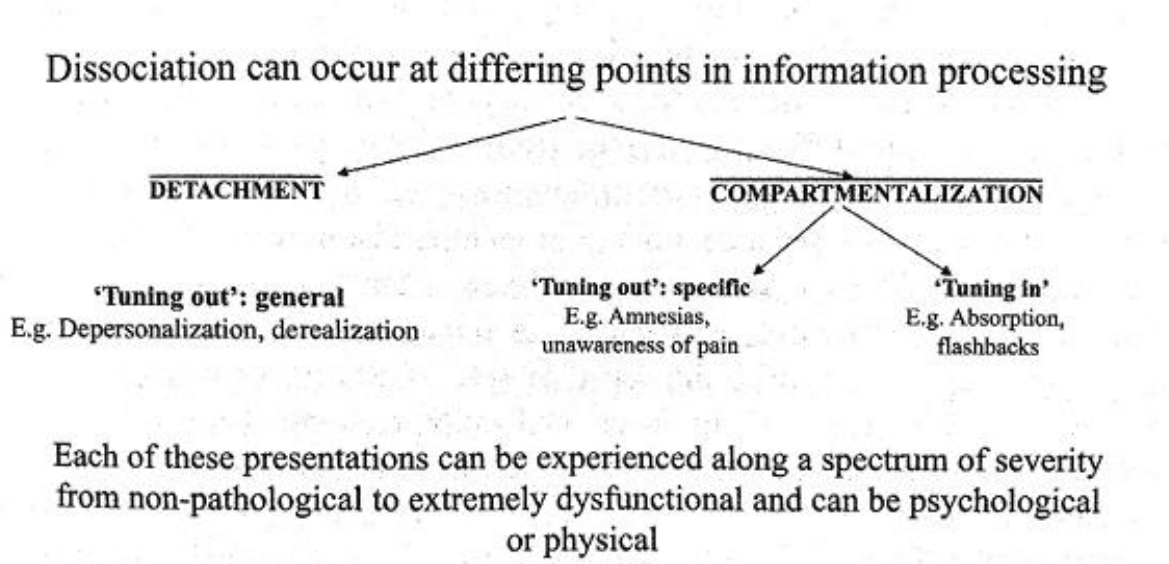

Figure 1 – The dichotomy model of dissociation (Kennedy et al., 2013, p. 13)

effective communication in between the two hemispheres of the brain in the suffering individuals.

Individuals suffering from *Dissociative Identity Disorder* typically have an average of 15 alter personalities (Barlow et al, 2018, p. 197). The typical age of onset has been observed to be around the age of 4, but the symptoms develop over a period of approximately 7 years before the disorder may be identified (Barlow et al, 2018, p. 197). There are a number of different causes that contribute to the onset and development of the disorder. Numerous studies have found the contributing factors to be in some way or the other linked to childhood experiences, trauma and other stressful events. As Spring (2012) identifies in their conceptualization, there may be two main contributing factors which may lead to a dissociative disorder: trauma and disorganized attachment. Childhood trauma can be a result of maltreatment or abuse by the primary care-giver (or the attachment-figure) in the developing years. Childhood trauma may be associated with a disorganized attachment pattern. This pattern or style of attachment develops within the first three years of age (Spring, 2012). It has been observed that childhood abuse is not the only source of trauma faced by the patients. In many patients, extremely stressful environments, or stimuli can act as sources of trauma (i.e. neglect, loss of loved ones, natural disasters, war, etc.). Some individuals, when confronted/exposed to trauma in childhood, have a "natural tendency to escape or dissociate from the unremitting negative affect associated with severe childhood trauma" (Barlow et al., 2018, p. 198). Research suggests that maltreatment faced by an individual during their childhood may contribute to problematic adult behaviors. In addition to the social stressors that might contribute to the development of Dissociative Identify Disorder, a number of biological contributions have been suggested as well. Spring (2012) elucidates, some individuals may carry higher biological tendency to experience dissociative phenomena. This may be due to physiological changes in the brain structure which then makes it difficult for the individual to engage effectively with their surroundings and their experiences. Patients who exhibit dissociative symptoms in adulthood have also been seen to experience and suffer from certain neurological conditions, particularly seizure disorders (Barlow et al., 2018, p. 199).

Numerous reasons have been presented to outline the causes of Dissociative Identity Disorder. DID has its roots in the childhood experiences of the suffering individual. Spring (2012) illustrates the vulnerability of traumatized children to DID. As children proceed through their development, they are physiologically and emotionally more vulnerable to developing the disorder. Children do not have an extensive understanding of their social and physical environment and they are less likely to cope effectively with traumatic experiences they may face. In addition, children who lack adequate emotional and social support are more susceptible to develop the disorder. "Exposure to verbal abuse from parents is associated with elevated psychological symptoms and white matter abnormalities" (Kandemir, et al., 2015, p. 373). Dissociation may arise out of these stressful and traumatic events and experiences. Research suggests that children who experience such traumatic events might use the dissociation as a defense mechanism to

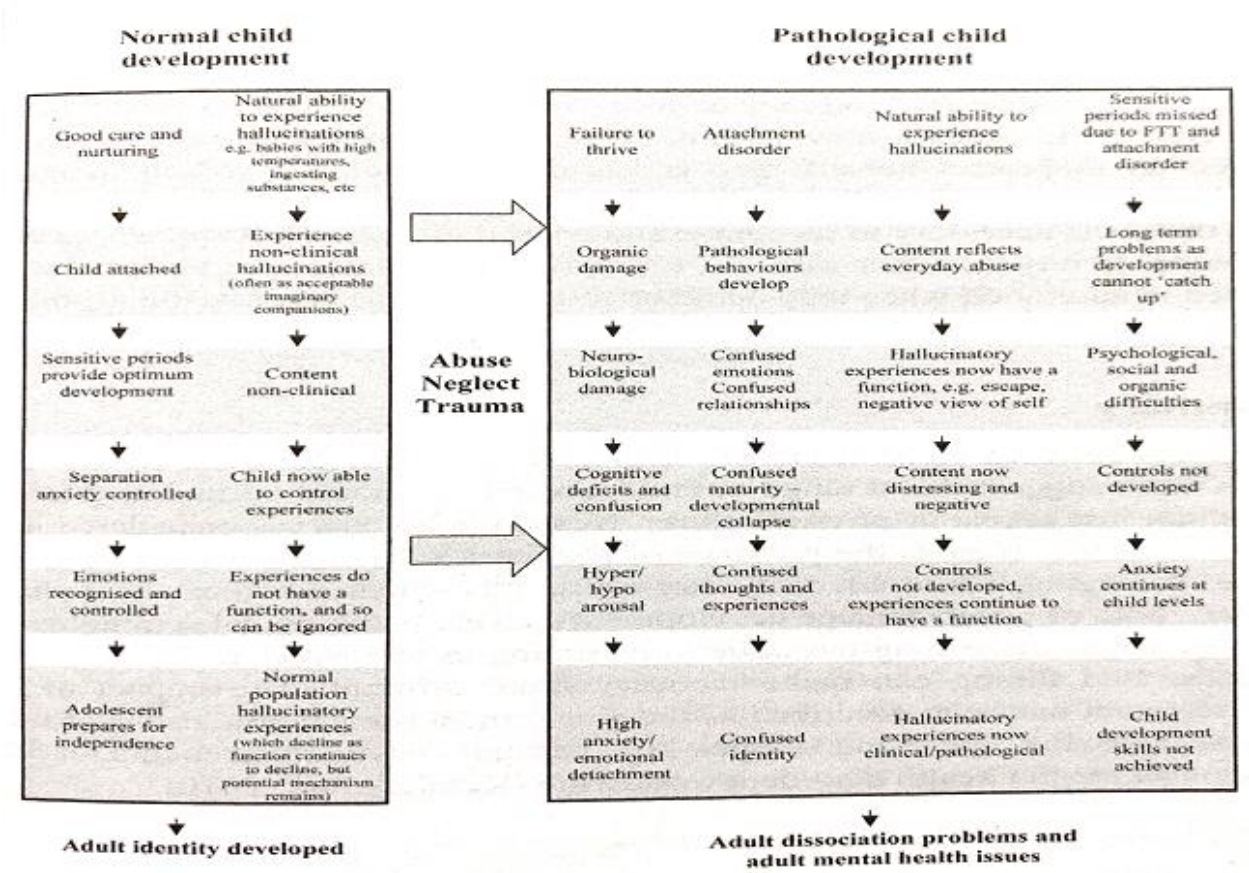

Figure 2 : Child Developmental Patterns (Kennedy et al., 2013, p. 51)

deny the experience and protect themselves from the adverse experiences.

Dissociative disorders are highly comorbid with disorders and/or conditions like anxiety, trauma, panic, depression, somatoform disorders, conversion disorders, etc (Barlow et al., 2018, p. 197).“Adolescents with DD (Dissociative Disorders) are more likely to experience higher rates of psychiatric comorbidity.” (Bozkurt et al., 2014, p. 371). Research conducted on comorbidity of *Personality Disorder* with dissociative disorders has found “ emotional abuse and severity of PD had a statistically significant effect on dissociation scores in patients. In addition, patients with severe dissociation symptoms had more pronounced Personality Disorder” (Ural et al., 2015, p. 470). Patients who displayed symptoms of Conversion Disorder (Functional Neurological Symptom Disorder) also showed a great deal of overlap with the symptoms of dissociative disorders and in some studies there was significant comorbidity with Bipolar Disorder and Posttraumatic Stress Disorder . “The age at onset of CD was also found to be significantly earlier in the DD(+) group compared to the DD(–) group...The rates for lifetime bipolar disorders and posttraumatic stress disorder were significantly higher in the DD(+) group than the DD(–) group (55% vs. 11.8% and 20.0% vs. 0%, respectively)” (Yayla, et al., 2015, p. 36).

Research by Webermann et al., (2015) suggests that in addition to higher rates of comorbidity, the patients with Dissociative Identity Disorder also display high rates of suicide and non-suicidal self-injury. Since Dissociative Identity Disorder appears to develop out of extreme environmental stressors and trauma in interaction with some biological vulnerability of the individual, these risk factors may predispose the individual to a number of other severe mental conditions.

Assessing a patient for a dissociative disorder can be a challenging task. The individual may display a multitude of symptoms which the clinician or psychiatrist might identify as part of another mental condition or disorder. "Because of their complex and coexisting symptoms, patients display elevated scores on a number of the scales on the MMPI and the MMPI-2. As such, their profiles are often technically invalid" (Stadnik et al., 2013, p. 547). Understandably, once the disorder is correctly diagnosed, treatment is not an easy task. Treatment for this complex disorder involves multifold approach. Apart from the efforts to reintegrate different alters through therapeutic alliance and confrontation, the treatment involves addressing trauma in an early stage of therapy. "The top DID therapists reported that they infrequently explored trauma in detail early in therapy .This is important because focusing too early on traumatic processing can be destabilizing" (Myrick et al., 2015, p. 62). "Revictimization can serve as a significant impediment to treatment progress. Sexual and physical revictimization is high among survivors of childhood sexual and physical abuse and is associated with increased posttraumatic stress disorder (PTSD) symptoms and dissociation" (Myrick et al., 2013, p. 376). With limited research based on treatment, much of the treatment approach comes from accumulated clinical wisdom. On one hand, treatment aims at a gradual reduction in the dissociative experiences and reintegration of the personalities and on the other hand, treatment focuses on associated and well-known psychological conditions like trauma, conversion and/or somatoform disorders, PTSD, etc.

In summary, research suggests that childhood experiences and traumatic events along with biological vulnerability are some of the main causes for the development of Dissociative Identity Disorder. Dissociative Identify Disorder develops in childhood due to the limited ability of some children to handle significant traumatic events. It has been proposed that dissociation develops as a defense and escape from intolerable situations. This can set the stage for the emergence of the disorder in some individuals. Distinguishing Dissociative Identity Disorder from common dissociative experiences has been made. A brief discussion about assessment and treatment and the extensive difficulties associated with them has also been included. Research in areas like - response of children to traumatic experiences, defense mechanisms used by individuals in their day-to-day lives and effects of known medicines and drugs, which are used to cure various psychological disorders, on individuals suffering from Dissociative Identity Disorder may contribute significantly.

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